EXPECTATIONS: Psychotherapy can be helpful in a variety of ways, including to assist you with the psychological adjustments that can be associated with childhood traumas, the transition to adulthood (including in the areas of education, employment and relationships with others), intimate relationships, child-rearing, parenting, divorce, co-parenting, aging, care-giving, illness, disability, addiction and loss. It can be helpful in alleviating the symptoms of depression and anxiety, and help you develop additional coping and problem-solving skills or strategies. It can be used on a short-term basis to address specific needs and concerns, or on an on-going basis, to pursue more comprehensive self-awareness, personal development, change and well-being. Typically, psychotherapy occurs weekly, at the same time each week.

MY GOALS: As your psychotherapist, I am committed to providing you with exemplary care. As part of that care, I will strive to:

- Listen to you attentively
- Communicate with you honestly
- Respect your right to engage in psychotherapy at your own pace
- Seek to understand you and your life and world from your own perspective
- Provide you with therapeutic guidance, insight and reflections responsive to your particular needs, circumstance and goals
- Invite you to share your thoughts and feelings with me, including regarding the process of therapy and how it affects you, and whether you are receiving what you want and need
- Regard you as a whole and complex person, inherently valuable and with many qualities and attributes beyond the difficulties, symptoms or vulnerabilities you may be experiencing
- Respect your right to direct and govern your own life, including to decide when you wish to discontinue the process of psychotherapy
- Help you recognize and draw upon your natural capacities and strengths to attain or sustain the well-being you desire
- Encourage you to seek alternative or adjunctive assistance if necessary to meet your needs
- Offer you psycho-educational information that may be helpful in broadening your awareness of those needs, situation, circumstance or experience we discuss
- Retain a focus on you and your needs in our sessions

SESSIONS: Sessions are generally 50 minutes in length and occur either once or twice a week, unless we have agreed in advance to an alternative duration or schedule. I may recommend sessions of 1.5 hours for couples and families or in other special circumstances.
FEE: You have agreed to pay the following amount ________ per session. Unless other arrangements are made, your payment will be due at the beginning of each meeting. Payment can be made by cash or check made out to Grateful Heart Holistic Therapy Center. A fee of $30 will be charged for any checks that are returned unpaid. I can provide you with a monthly statement outlining the payments you have made for your sessions. You can use the statement for tax purposes or for reimbursement if you have a Health Savings Account (HSA). I will review your fees each year in January, when Grateful Heart typically institutes a nominal fee increase of $5 to $10 per client. You will receive a month’s notice before any changes are made in your fees.

CANCELLATION: If you need to reschedule or cancel an appointment, please provide at least_____ hours’ notice by calling my private voice mail. A full session fee will be charged for any session that is missed or cancelled without the requested notice.

CONFIDENTIALITY: With the exception of certain specific exceptions described in this agreement, the information that you share in psychotherapy is confidential and will not be discussed or released to anyone without your written permission and consent, unless required by law. I cannot and will not tell anyone else what you have shared with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will only do so in the event of an emergency or for the purposes of consultation. I will always act to protect your privacy even if you authorize me to release information to another party. You may direct me to share information with whomever you choose, and can also revoke that permission at any time. If my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the couple/family. You may direct me to share information with whomever you choose, and can also revoke that permission at any time.

The following are legal exceptions to your right to confidentiality:

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or tell me about someone else who is abusing a child or vulnerable adult, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I am legally permitted to call the police or our county’s mobile crisis response team. I am not obligated to do this, and would pursue other options with you before-hand if possible. If you cannot take steps to guarantee your safety, I will call 911 to conduct a welfare check or call the local crisis team.
4. If you are being seen as part of a couple or family, you will be asked to review and sign a special agreement which outlines exceptions to confidentiality as it relates to your partner/family member.
COUPLES AND FAMILIES: If you are being seen as part of a couple and/or family, please note that I consider that couple or family to be my client (the “treatment unit”). For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the couple/family before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the couple/family. During the course of my work with a couple or a family, I may see a member or members of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually. This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the successful treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

AVAILABILITY: If you need or want to speak with me in between sessions for reasons concerning scheduling or other urgent or timely matters, please call my private voice mail number and I will return your call as soon as possible, generally within 24 hours. Please be clear in your message regarding whether you wish to speak with me immediately.

EMAIL, TEXT MESSAGING AND SOCIAL MEDIA: I will not use email or texting to communicate with you unless you give me permission. Unless we have made another agreement, email and text correspondence will be for administrative purposes only. Email and text messages are not completely confidential. Please do not use text or email for emergencies, casual conversations or clinical matters. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your session. The telephone or face-to-face context simply is much more secure and effective as a mode of communication. Please also note that I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Facebook or Linked-In and do not use encrypting of emails at this time.
EMERGENCY: I do not have 24-hour emergency or “on call” coverage. If you believe you will need a therapist with 24-hour coverage I will be happy to provide you with a referral to an agency. If you are experiencing an emergency, and I am not available to assist you in acquiring the appropriate services, please go to your nearest emergency room or call 911. When I am out of town for an extended period of time, I will give you the name of a colleague you can contact in case of an urgent need.

INSURANCE: If you are enrolled in an insurance program that provides reimbursement for out-of-network psychotherapy, I can provide you with a monthly service and fee statement if requested. I cannot bill your insurance carrier directly.

DIAGNOSIS: If you are submitting bills to your insurance carrier for reimbursement, I am normally required to provide them with a diagnostic code. If I provide you with a diagnostic code, I will discuss it with you in advance.

RECORD-KEEPING: I keep brief records of each session noting the dates we meet, the topics we cover, progress reports from the client’s perspective, interventions and impressions from the therapist and next steps.

DISCONTINUATION: You can discontinue psychotherapy at any time. If possible, I recommend reserving a minimum of two to three weeks for a closure process, so you can leave with a sense of completion. If for some reason, I have determined I cannot or am not assisting you effectively, I will refer you to other providers.

SUPERVISION: As an intern, I am required to participate in weekly supervision sessions with a licensed practitioner with the qualifications and training to oversee the work of therapists in training. Other clinicians in training may participate in these sessions with me. Any material discussed in these sessions is subject to the same rules and guidelines outlined in this agreement.

CLIENT CONSENT TO PSYCHOTHERAPY: I have read and considered this agreement carefully. I have clarified any questions I have, and understand all that is specified in this agreement.

I understand that I will be receiving psychotherapy from the following therapist:

Name: ____________________________________________

I understand that this therapist is a:

_____Marriage Family Therapist Trainee/Registration Number: ______________________
_____Marriage Family Therapist Intern/ Registration Number: ______________________
I understand also that the therapist is supervised by an experienced Marriage Family Therapist, trained in supervision. I have been advised their supervisor’s name is ________________________________ and that their license is:_______________________________.

I have read this Psychotherapy Agreement, and agree to its terms, by signing below.

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